

Sawako Nakamura, MS, L.Ac., CMT

Patient Information Sheet

CONFIDENTIAL

Patient Information

Last Name:	First Name	Middle:
Address:		
Tel. - Home:	Work:	Mobile:
Fax:	E-mail:	
Would you like to receive e-mail reminders prior to appointments? <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Date of Birth:	Age:	Occupation:
Employment Status (check all that apply): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student		
Emergency Contact:	Relationship:	Phone:
Social Security #	Height:	Weight:
Referred by:		
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other:		

Confidentiality: Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

Primary Care Physician Information

Primary Physician:	Telephone:
Physician's Address (or name of clinic/hospital):	

Insurance Information (if applicable)

Insurance Company: Relationship to Patient:	Policy Holder Name:
Insurance Company Address:	Telephone:
Policy # / ID #:	Group #:

Sawako Acupuncture

Sawako Nakamura, MS, L.Ac., CMT

Patient Intake Form

Patient _____ Date _____

Major Complaint(s), in order of importance to you:

	Severe	Moderate	Slight	Major Complaint	How Long?	Pain Level (1-10)
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

FAMILY HISTORY: Complete for each family member, placing an X in the appropriate box.

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							
Other							

TRAVEL – Have you ever traveled or lived outside of the U.S.? Yes No

Any health problems when abroad? Yes No If yes, what? _____

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription Name	Purpose	How long	Dose	How often	Last Dose

MEDICAL CONDITIONS – Please list conditions & surgeries you have or have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food	OCCUPATIONAL CONCERNS Check () if your work exposes you to the following:
Year	Condition/Surgery		Occupation
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Heavy Typing/Computer Use
			<input type="checkbox"/> Hazardous Substances
			<input type="checkbox"/> Heavy Lifting
			<input type="checkbox"/> Other

FEMALES -

Form of birth control _____ Pregnant Yes No Clotting Hot flashes

Last period _____ Last PAP test _____ Heavy bleeding Vaginal dryness

Age started menstrual cycle _____ Age stopped _____ Vaginal discharge Other _____

Menstrual Pain Water retention No. Pregnancies _____

Low backache Mood changes No. Vaginal Deliveries _____ No. Miscarriages _____

Irregular menses Painful breast No. Cesareans _____ No. Abortions _____

SYMPTOMS – For each symptom you currently have, rate its severity from 1-3 (3 being worst). Leave blank if N/A.

LIVER/GALLBLADDER

- Irritability
- Depression
- Headaches/migraines
- Visual problems
- Red eyes
- Dry/itching eyes
- Spots in front of eyes
- Blurred vision
- Feeling of lump in throat
- Clenching of teeth at night
- Muscle cramping
- Muscle twitching
- Joints feel tight/stiff
- Cold hands/feet
- Soft/brittle nails
- Craving/avoiding sour foods

KIDNEY/URINARY BLADDER

- Urinary problems
- Frequent urination
- Incontinence
- Weakness/pain in lower back
- Aching bones
- Feel cold easily
- Low sexual energy
- Excess sexual desire
- Poor memory
- Loss of hair
- Hearing problems
- Ringing in ears
- Craving/avoiding salty foods

HEART/SMALL INTESTINE

- Heart palpitations
- Chest pain
- Dizziness
- Insomnia
- Easily startled
- Restlessness/agitation
- Anxiety
- Breathlessness
- Vivid dreams
- Dreams are bothersome
- Lack of joy in life
- Laughing for no reason
- Craving/avoiding bitter foods

LUNG/LARGE INTESTINE

- Dry cough
- Cough with sputum
- Nasal discharge
- Poor sense of smell
- Nose bleeds
- Itchy, red or painful throat
- Dry mouth
- Skin rashes
- Itchy skin
- Grief, sadness
- Shortness of breathless
- Allergies
- Low resistance to colds or flu
- Low physical stamina
- Mild fever comes and goes
- Craving/avoiding spicy foods

SPLEEN/STOMACH

- Heaviness anywhere in body
- Fatigue
- Hard to get up in the morning
- Edema (swelling)
- Muscles feel tired often
- Easy bruising and bleeding
- Bad breath
- Low appetite
- Snacking
- Tendency towards hypoglycemia
- Difficulty digesting oily foods
- Nausea
- Vomiting
- Gas/belching
- Bloating
- Hemorrhoids
- Constipation
- Diarrhea
- Abdominal pain
- Indigestion/heartburn
- Over-thinking
- Tendency to become obsessive
- Craving/avoiding sweets

OTHER

HABITS – Please check any habits which apply to you now or in the past

- Coffee Yes No # per day _____ age started _____ age quit _____
- Tobacco Yes No # per day _____ age started _____ age quit _____
- Marijuana Yes No # per day _____ age started _____ age quit _____
- Alacohol Yes No # per day _____ age started _____ age quit _____
- Crack/Cocaine Yes No # per day _____ age started _____ age quit _____
- Heroin Yes No # per day _____ age started _____ age quit _____

Please describe any restricted diet you follow(ed) now or in the past

Please describe your typical daily diet -

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

Please describe any regular program of exercise -

Have you ever had an Acupuncture treatment. When and for what reason?

Sawako Nakamura, MS, L.Ac., CMT

Patient Informed Consent Agreement

I agree to receive acupuncture treatments and related therapies by Sawako Nakamura L.Ac.. Treatment methods may include, but are not limited to acupuncture, Asian massage and bodywork, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that Sawako Nakamura L.Ac. uses only sterile disposable single-use needles, and maintains a clean and safe environment. Asian massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Sawako Nakamura, L.Ac. immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Sawako Nakamura, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I will notify Sawako Nakamura, L.Ac. if I am or become pregnant.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

If I am unable to make a pre-scheduled appointment, I agree to cancel at least 24 hours in advance. I understand that failure to do so will result in my being charged the full amount of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my time-slot may be given to another client.

I understand that Sawako Nakamura L.Ac. has the right to refuse treatment to any patient at anytime. Reasons for refusal of treatment include crude behavior or inappropriate conduct.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Name of Patient (and Representative)

X _____
Patient Signature

Today's Date

Sawako Nakamura, MS, L.Ac.
Print Name of Practitioner

X _____
Sawako Nakamura, MS, L.Ac.

Sawako Nakamura, MS, L.Ac., CMT

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPPA," it is our legal duty to safeguard your Protected Health Information (PHI). Our office is dedicated to providing service with respect for human dignity. Protecting you privacy and you health care information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in the law.*

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information by submitting the authorization in writing. Such disclosure will be made to any personal representative you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters, and appointment reminders, by telephone calls, mail, or email.

Disclosure

This office may use or disclose you Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restriction on the disclosure of your Protected Health Information.
4. You have the right to request that we amend you Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions about this Notice or any complaints about our privacy practices, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201.

This Notice went into effect on March 1, 2007.

I acknowledge consent for use and disclosure of Protected Health Information and receipt of this Notice of Privacy Practices.

Signature of patient or patient's personal representative Date

Printed name of patient or personal representative Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature on this HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Sawako Nakamura, MS, L.Ac., CMT

Appointment And Financial Policy

Welcome to the office of Sawako Acupuncture. We are delighted to have you as a new patient and look forward to providing you with the highest quality care. In order to optimize our relationship, please take a minute to carefully read our appointment and financial policy.

Appointment Policy

Many patients are surprised to find that we are usually on time. This is because your treatment time has been reserved for you. Our time and expertise are what you essentially pay for. If you expect to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice for canceled or rescheduled appointments is required or your standard treatment fee may be assessed. This allows us time to schedule another patient and the time is not lost.

Financial Policy

Thank you for choosing Sawako Acupuncture for your health care needs. We are committed to your improved health by providing appropriate, high quality, comprehensive family health care. While our intention is to assist you, it is your responsibility to ensure that all services rendered by Sawako Acupuncture on your behalf are paid in full. In order to understand our Financial Policy, we have listed below our financial requirements.

Patients Without Insurance Coverage

Payment at the time of service is required. Cash, Check, Visa, Master, Discover, and American Express Card are accepted as payment options.

Patients With Insurance Coverage

We can verify acupuncture coverage for you. Your treating acupuncturist may be an in-network provider. However, if we are out-of-network but you have acupuncture coverage, you will be expected to pay at the time services are rendered. We will then provide you with an invoice to submit to your insurance company for direct reimbursement to you.

Any questions I have concerning my appointments have been answered. I have read this statement and fully understand it.

Signature of patient or patient's personal representative

Date

Printed name of patient or personal representative

Relationship to Patient